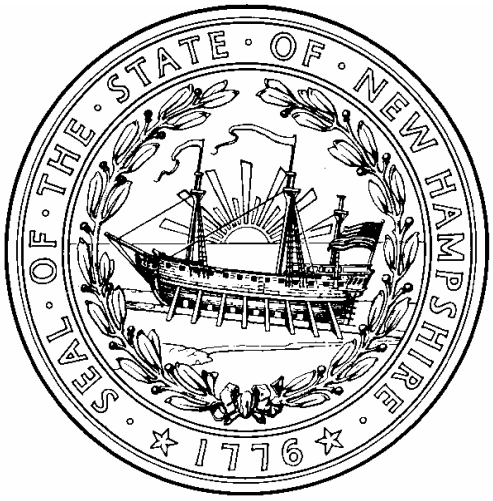

Functional Needs Guidance

Support Document
To The
State Emergency Operations Plan

Accepted by Governor John Lynch

March, 2007

Prepared by:

New Hampshire Functional Needs Guidance Committee

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TABLE of CONTENTS

NH Functional Needs Guidance Committee **5**
Introduction **6**
Purpose **6**
Process **6**
Audience **7**
Assumptions **7**
Authorities **8**
State of New Hampshire Functional Needs Guidance
Considerations for Planners **9**
Altered Standards of Care **9**
Volunteers and Credentialing **9**
Communication Technology **10**
Liability **10**

Section 1 - Preparedness **11**
A. Individuals with Functional Needs – Defined **11**
B. Locating Functional Needs Populations **14**
C. Reaching Functional Needs Populations **15**
D. Individual and Family Preparedness **16**

Section 2 - Response **17**
A. Alert and Notification **17**
Deaf and Hard-of-Hearing **17**
Blind or Low Vision **18**
Cognitive Impairment **18**
B. Evacuation **18**
Evacuation Kit **18**
Evacuation Plan Components **18**
Transportation **19**
C. Sheltering **20**
Congregate Care Facilities **21**
Temporary Medical Infirmary **22**
Emergency Temporary Relocation of an Acute and/or Chronic Medical and other Fixed Facilities **24**
Animal Shelters **24**
Sheltering of Criminal Offenders **24**
Reverse Evacuation **25**
Sheltering-in-Place **25**

Section 3 - Recovery **25**
A. Short-Term Recovery **26**
B. Re-Entry/Return to Residential Areas **26**
C. Long-Term Recovery **26**
D. Coordination/Restoration of Services **27**

Appendices

Appendix A – References **28**
Appendix B – Acronyms **31**
Appendix C – Glossary **35**
Appendix D – All Health Hazards Regional Map **39**
Appendix E – Authorities **41**
Appendix F – Limited Liability for Agents Assisting Certain State Departments **45**
Appendix G – HIPAA Privacy: During an Emergency **50**
Appendix H – Media Outlets Serving Non-English Speaking Populations in NH **52**
Appendix I – NH Functional Needs Populations Directory of State and Federal Resources **54**

NH Functional Needs Guidance Committee

Dan Brennan, Concord Chapter – American Red Cross	Cheryl Killam, Governor's Commission on Disability
John Capuco, Developmental Services Bureau	Ralph Littlefield, Community Action Program
Stephen K. Crawford, DVM, NH State Veterinarian	Susan Lombard, DHHS, Elderly and Adult Services
Paul Deignan, Homeland Security and Emergency Management	John McDermott, DHHS, Juvenile Justice Services
Roger Desrosiers, DHHS, Children, Youth and Family Services	David Ouellette, Developmental Disabilities Council
John Disko, Homeland Security and Emergency Management	Michael Racette, DHHS, Office of Minority Health
Sonke Dornblut, Institute on Disabilities, University of New Hampshire	Ken Roos, DHHS, Elderly and Adult Services
Claudia Ferber, NH – National Alliance on Mentally Ill	Carole Totzkay-Sitar, Homeland Security and Emergency Management
Colleen Fitzpatrick, Great Bay Chapter – American Red Cross	Richard Verville, Homeland Security and Emergency Management
Terry Jarvis, DHHS, Health Facilities & Community Residences Licensure & Certification Bureau	Martha Young, DHHS, Homeless, Housing, Transportation Unit
Capt. Chris Kench, Department of Corrections	

Contact Information for this Guidance is:

New Hampshire Department of Safety
Homeland Security and Emergency Management

Phone: (603) 271-2231

This guidance reflects the efforts of many people. We sincerely appreciate and acknowledge the work from various states' emergency management planners and responders, public health services administrators, and from Federal documents in the creation of this New Hampshire Functional Needs Guidance.

INTRODUCTION

The Constitution of the State of New Hampshire mandates that every town and city is responsible for the health and safety of their citizens. Regional and State agencies have been created to assist local government to fulfill this mandate.

The New Hampshire Department of Safety - Homeland Security and Emergency Management (HSEM) established a framework, the State Emergency Operations Plan (State EOP), for State government to provide assistance in an expeditious manner to save lives and to protect property in the event of any disaster or emergency situation. To facilitate effective response operations, the State EOP incorporates a functional approach that groups the types of assistance to be provided into Emergency Support Functions (ESFs) (i.e., communications and alerting, health and medical, transportation, etc.).

The State EOP framework has been adopted by many New Hampshire towns and municipalities. It provides local government with a structure to initiate, coordinate and sustain an effective local response to disasters and emergency situations. Citizens expect their state and local government to keep them informed and to provide assistance in the event of an emergency or disaster. All levels of government, working closely with the private sector, share the responsibility for including the needs and talents of individuals with a full range of functional abilities in the emergency management process. Preparedness, response recovery and mitigation planning requires the capacity to reach every person, including those with functional needs.

HSEM appreciates the continuing cooperation and support from all the State departments and agencies and from the volunteer and private organizations which have contributed to the development and publication of this guidance.

Purpose

The State of New Hampshire Functional Needs Guidance is intended to support the State EOP. Through the integration of planning efforts at the local level and within New Hampshire's All Health Hazards Regions' (AHHRs) emergency management framework, the capability to accommodate and assist individuals with every day functions in an emergency at the state and local levels will be improved.

Process

The New Hampshire Department of Safety - Homeland Security and Emergency Management (HSEM) and the New Hampshire Department of Health and Human Services (NH DHHS) have been working for several years to create a special needs population planning guide. As a result of recent national natural disasters negatively impacting special needs populations, many states are revising State and Local EOPs' including the term "special" populations. Although terminology continues to evolve, the State Functional Needs Guidance Committee has proposed a collective term, "functional" to describe populations that under usual circumstances are able to function on their own or with support systems.

New Hampshire has begun the process to revise state emergency planning documents to reflect the accommodation of individuals with functional needs. This document will use the terms "individuals with functional needs" and, where necessary, identify approaches and/or concerns specific to groups within this broad population.

The content of the document incorporates consensus from discussions that occurred outside of the Committee with a variety of colleagues. These discussions included:

- The National Working Conference on Emergency Management and Individuals with Disabilities and the Elderly, Washington, DC, June 28-30th, 2006
- Federal Emergency Management Agency (FEMA) Regions Quarterly Reports on planning, outreach, and training activities associated with the recommendations of the National Working Conference on Emergency Management and Individuals with Disabilities and the Elderly.
- Multiple federal workgroups conducted by FEMA, Health and Human Services (HHS) and Department of Homeland Security (DHS).

This is a dynamic document that will continue to be enhanced and modified based on lessons learned from exercises, real events, and science and policies developed at the national and State level.

Audience

The intended audience for this document includes, but is not limited to: State government agencies and officials, local government agencies and officials, AHHR groups, functional needs population stakeholders, private sector, businesses, and Emergency Support Functions primary and support agencies.

Assumptions

1. This document is intended to support the State Emergency Operations Plan.
2. This Functional Needs Guidance will coordinate with and complement existing State readiness initiatives including, but not limited to:
    a. *The New Hampshire Public Health Emergency Preparedness and Response Plan*.
    b. *Influenza Pandemic Public Health Preparedness and Response Plan*.
    c. *Smallpox Public Health Preparedness and Response Plan*.
    d. *Animals in Disaster Resource Directory*.
3. There are many documents referenced in this guidance, marked in *italics*. Please refer to Appendix A, References for information on where these documents are available.
4. This document includes data obtained from the *New Hampshire Special Populations Emergency Preparedness Needs Assessment* conducted in 2005 through the Department of Safety (DOS), then Bureau of Emergency Management (BEM), in collaboration with the Community Health Institute. It focused primarily on the issues surrounding emergency preparedness and response for elderly and individuals with hearing and sight disabilities living in NH.
5. Some individuals with functional needs may not want or accept assistance from responders or community members.

6. Emergency human services are vital for the long-term recovery of a community infrastructure.
7. A sustained long-term commitment to providing human services is needed to restore the community and all residents to a state of mental, physical and social well-being.
8. The State guidance will be updated based on new information, especially from the United States Department of Homeland Security (US DHS) and other federal agencies.

Authorities

The United States has numerous regulations and laws which are designated to prohibit discrimination and ensure adequate access to services for individuals with functional needs. The summary list in Appendix E, Authorities contains both federal and State laws, regulations, and statutes pertinent to emergency preparedness and response. It is not intended to be a comprehensive legal or policy review. Rather, it is to provide background information to assist in framing the Guidance.

State of New Hampshire Functional Needs Guidance

Considerations for Planners

Planners should consider:

- Diverse population density, from dense urban areas to sparse rural areas
- The contiguous borders of Canada, Maine, Massachusetts, and Vermont
- Medical surge
- Seasonal population changes
- Multiple communication strategies

Altered Standards of Care

During medical surge emergencies, there may be shortages of healthcare resources that will necessitate altered standards of care. The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved. Changes in the usual standards of health and medical care in the affected region will be required to achieve the goal of saving the most lives in a mass casualty event. Rather than doing everything possible to save every life, it will be necessary to allocate scarce resources in a different manner to save as many lives as possible. Protocols for triage need to be flexible enough to change as the size of a mass casualty event grows and will depend on both the nature of the event and the speed with which it occurs. Information on altered standards of care during medical surge emergencies is available in the *NH Medical Surge Guideline*.

Volunteers and Credentialing

An emergency situation may create the need for and/or result in large numbers of volunteers. Sources of volunteers include:

- The Northern New England Metropolitan Medical Response System Medical Strike Team (NNE MMRS MST)
- Medical Reserve Corps (MRC) unit
- Retired or currently unemployed but qualified volunteer health care providers
- NH Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and other States' ESAR-VHP database
- Volunteer Organizations Active in Disasters (VOAD)
- Faith-based organizations (FBOs)
- Non-governmental organizations (NGOs)
- Community-based organizations (CBOs)
- Disaster Behavioral Health Response Teams (DBHRT)
- Community Emergency Response Teams (CERT)

The State will continue to develop and advocate the use of ESAR-VHP for emergencies in the State (and across State lines, as warranted). Information and on-line applications can be found at:

https://nhlicenses.nh.gov/MyLicense%20VHP/. The preferred method of volunteering is through formalized teams and other community or State organized efforts. MMRS Strike Team, CERT, MRC, Red Cross, DBHRT, and local community efforts allows pre-credentialing and identification, training and exercising, and command and logistical support. AHHRs, Acute Care Centers (ACCs), or municipalities may solicit the State ESAR-VHP for help to respond to a sheltering capacity emergency. Requests for volunteers through ESAR-VHP should be coordinated through the local Emergency Operations Center (EOC) / Incident Command (IC) and the State EOC. When physicians and other medical professionals report to an ACC or request institution for duty, the credentialing and verification process will already be complete, and a temporary identification badge will have been issued. NH DHHS or the State EOC may request on its own behalf, or on behalf of a municipality or an institution, help from another state. The ESAR-VHP systems in other states will be coordinated with the NH ESAR-VHP; these requests shall be handled under the Emergency Management Assistant Compact (EMAC). The EMAC is a mutual aid compact that states have signed which allows for the sharing of critical resources, including personnel, during the time of an emergency http://www.emacweb.org/.

Communication Technology

The State of New Hampshire Department of Safety, Division of Emergency Services provides Automatic Number Identification / Automatic Location Information (ANI/ALI). However, amendments to the current ANI/ALI documentation form would need to include close ended checkboxes for registrants to indicate their specific emergency service needs and incorporating this information into a searchable State Communications database. Other recommendations for enhancing the accessibility of the current ANI/ALI State form include using larger print, developing an outreach program with brochure that explains the program in more detail, developing an internet-based sign-up sheet, and using existing agencies and community-based organizations (CBOs) such as Granite State Independent Living or home healthcare agencies to distribute the forms.

Liability

- The current approach in New Hampshire law on the topic of liability protection for persons assisting in public health and other emergencies in New Hampshire is explained in the Revised Statutes Annotated (RSAs), TITLE LII: ACTIONS, PROCESS, AND SERVICE OF PROCESS, CHAPTER 508: LIMITATION OF ACTIONS, (see especially sections 12 and 17 located in Appendix F. Further information on this and other RSAs is available at: http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-LII-508.htm).
- Refer to Appendix G for changes in Health Insurance Portability and Accountability Act (HIPAA) Privacy during an emergency.
- Additional legislation will be introduced in the 2006-2007 legislative season.

SECTION 1 – PREPAREDNESS

Preparedness activities develop emergency response capabilities. Planning, exercise, training, mitigation, developing public information programs and alerting and warning are among the activities conducted under this phase of emergency management to ensure the most effective and efficient response in a disaster. Preparedness seeks to establish capabilities to protect people from the effects of disaster in order so save the maximum number of lives, minimize injuries, reduce damage and protect property. Procedures and agreements to obtain emergency supplies, materials, equipment and people are developed.

The general vision of NH and local emergency planning is to reach every person who resides, works, or travels through NH and its communities. A comprehensive understanding of who is in the state or community at any given time and how best to reach them with messages or for evacuation is critical.

A. Individuals with Functional Needs – Defined

As described in Appendix B, Glossary of this document, "individuals with functional needs" is a collective term to describe a population that under usual circumstances are able to function on their own or with support systems. During an emergency, their level of independence is challenged. As outlined in **Table 1**, they may feel they cannot comfortably or safely access and use the standard resources offered in disaster preparedness, response and recovery.

Table 1

Being Dependent on Support Services – People who depend on others or community support services to function independently or perform daily activities, may become vulnerable in disasters when these "lifelines" are disrupted.	→	**1. Some Senior Citizens** **2. People with Disabilities** **3. People who are Non-English Speakers** **4. People who are Culturally or Geographically Isolated** **5. People with Substance Abuse Issues** **6. People who are Homeless, Marginally Housed or Shelter Dependent** **7. Children with Special Circumstances** **8. People Living in Poverty** **9. Illegal Residents** **10. Single-Parent Households**
Residing in High-Risk Areas – People who live in the older or lower income parts of town are exposed to more of the physical structural damage from disasters.		
Limited Access – People who lack resources, trust, knowledge, or ability to access traditional systems frequently have great difficulty with recovery.		
Social Status – People lacking money, education, jobs, or other resources may have fewer resources with which to recover from disaster.		
No Support Systems – People who live on very low incomes cannot prepare for disasters and may not have adequate support systems pre or post disaster.		

Source: "Meeting the Needs of Vulnerable People in Times of Disaster: A Guide for Emergency Managers. OES California, May 2000.

Defining functional needs populations is an ongoing process, as the people and their needs and vulnerabilities change over time. It is important that the information (data) collected be organized in ways that are accessible and easy to amend. For example, if there are several group settings in a community, the point-of-contact names and phone numbers should be placed in the local EOP. This information should be updated whenever necessary and at least once a year.

Each AHHR should define the functional needs populations within their communities and the agencies, if any, that serve them. The following research and fact finding steps, adopted from the Centers for Disease Control *Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency*, should be considered:

1. Collect population information and data using Census and other national and State data as well as data developed just for your community (studies conducted by area agencies or quasi-governmental organizations, such as a Metropolitan Planning Organization [MPO]).

2. Establish baseline criteria to define functional needs populations in your community.

3. Estimate the number of people in functional needs groups who live in your community (or jurisdiction, or whatever area you are addressing).

4. Select up to five broad categories of population descriptors that will provide access to the most numbers of people. As time and resources permit, this list can be expanded, but selecting five will let you begin your planning with a manageable body of information.

5. Identify key contacts, community-based organizations (CBOs), and State government agencies and collect phone numbers, e-mail addresses, and postal addresses. (See **Table 2**. What CBOs Bring to Emergency Management)

6. Facilitate discussions with key contacts. Topics can include:
   a) The issue and process of defining functional needs populations
   b) Long-term goals and objectives
   c) Other people who should be part of the discussion and their contact information
   d) Information about the population under discussion

7. Survey representation of overarching organizations and government agencies to learn:
   a) Their interaction (or lack of) with function populations in your community
   b) Names and contact information for direct service providers and advocacy organizations that work with functional needs populations
   c) Barriers functional needs populations have to receiving routine health or emergency information.

8. Commit to regular contact with members of your community network and build in opportunities for them to give you feedback about their involvement.

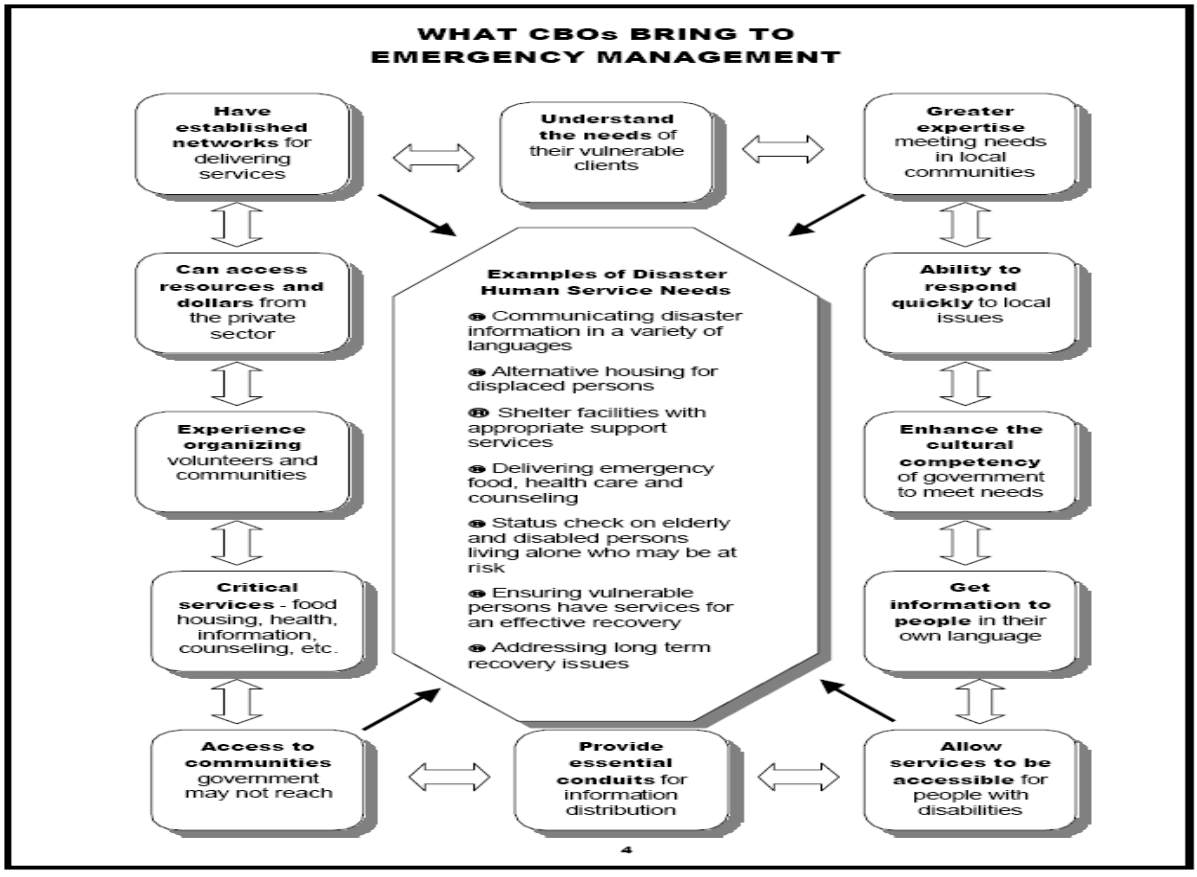
9. Develop a database that includes:
   a) Broad categories of three to five functional needs populations

b) Contact information on key representatives or trusted sources from overarching groups and governmental agencies

10. Expand your database to include:
    a) New functional needs population demographics and characteristics gathered from research
    b) Contact information for organizations and agencies that provide services, such as human service, government agencies, tribal, CBOs, businesses, and other who work with functional needs populations

Note: While the State does retain a database of some functional needs individuals, this database is in compliance with the Radiological Emergency Response Preparedness/Plan (RERP). Database management should be discussed at the local level. There was consensus among State agencies during the September, 2006 Working Conference that due to the changing nature of all contact information, local lists may be more likely to be accurate. There was concern that self-identification may not be reliable. People may not consider themselves as being in need of assistance. Some State agencies thought that people should be encouraged to complete phone information for E-911 ANI/ALI as relevant.

Table 2. What CBOs Bring To Emergency Management



Source: "Meeting the Needs of Vulnerable People in Times of Disaster: A Guide for Emergency Managers. OES California, May 2000.

B. Locating Functional Needs Populations

After defining the functional needs populations across the State, determine where these groups of people reside, work and gather. Mapping is used by some states' fire departments and cities in evacuation planning, but to date most communities in NH have not mapped functional needs populations. Geographic dispersion can go a long way towards strengthening relationships with State and local organizations that can play key roles in preparedness, response and recovery.

The best method for locating functional needs populations would include Geographical Information Systems (GIS) technology and data resources such as the US Census, combined with community collaborations and networking. A US study on marginalized populations found GIS an important tool in understanding the dynamics of population diversity and as a means of assessing marginal solutions (Alexander, Kinman, et al). GIS databases have been used extensively for many years to help institutions, business, and federal, State and local governments collect and analyze information to make better solutions. The NH Department of Safety, Division of Emergency Services can assist communities interested in GIS mapping. When inquiring about GIS software, be sure to mention the purpose you want it to serve.

Each AHHR should locate the functional needs populations within their communities and the agencies, if any, that serve them. The following research and fact finding steps, adopted from the Centers for Disease Control *Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency*, should be considered:

1. Assess existing processes within your department or agency for locating functional needs populations.

2. Choose GIS mapping or alternate methods to locate functional needs populations.
    a) If departmental resources are not available for GIS mapping programs, consider working with a partner organization, such as a local Metropolitan Planning Organization (MPO), Department of Transportation, fire departments, or election offices, many of which have access to such resources.
    b) If electronic mapping is not available, consider using colored pins or dots placed on a map of your community to indicate the size and locations of defined functional needs populations.
    c) Using Census and other data previously collected in the defining stage, locate on a map the neighborhoods or communities where members of functional needs groups live in significant numbers.

3. Locate and map gathering places for the broad categories of functional needs populations (e.g., community centers, missions, faith-based facilities, etc).

4. Identify and map trusted information sources representing functional needs groups.
    - Collect names, telephone numbers, e-mails and mail addresses

5. Facilitate discussions with key CBO leaders having networks and ties.
    - Arrange roundtable meetings or conference calls.
    - Discuss goals, objectives, roles, and common issues surrounding the challenges in accurately locating functional needs populations.

6. Establish a Community Network of overarching organizations, service providers, businesses, and others who work with functional needs populations.
    - Members of this network are your community collaborators and program partners.
        - Maintain regular contact with the community network through a newsletter, conference calls, or meetings.

7. Develop an agreement stating the terms of collaboration. Choose between a formal agreement and an informal agreement.

8. Expand your existing computer database by storing additional names and contact information for community collaborators and program partners. Also include functional needs population gathering places in the database.

9. Update and backup databases of all the community organizations that you've worked with to locate functional needs populations because it will be important for reaching functional needs populations.

C. Reaching Functional Needs Populations

The primary goal of emergency messages is to motivate people to take a desired action. This is easier said than done; it requires an understanding of how to reach the targeted populations in ways that grab their attention and change the way they think so they will take action. There are many communication methods that can be used such as, phone, radio, television, bill inserts, word-of-mouth/hand, languages spoken and signed, and social and community networks. For people to act, they must understand the message, believe the messenger is credible and trustworthy, and have the capacity to respond.

Risk communication principles and practices are universal. There is no need to develop a separate functional needs population outreach communication plan. Every community's risk communication should have the objective of equity in outreach so that no one is left unprotected.

Utilize the collaboration and research already started as a basis for implementing communication and outreach processes that take into consideration the ways in which functional needs populations receive information and act on information.

Each AHHR should outreach to the functional needs populations within their communities and the agencies, if any, that serve them. The following research and fact finding steps, adopted from the Centers for Disease Control *Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency,* should be considered:

1. Survey people from agencies and organizations to learn their successes and failures in reaching functional needs populations.

2. Conduct focus groups or community roundtables with members of different functional needs populations to identify their needs and barriers to communication.

3. Analyze data gathered from the surveys, focus groups, and previous research efforts in defining and locating functional needs populations. Look for common themes.

4. Collaborate with community organizations to develop messages and materials to reach functional needs populations.

5. Develop and test messages for cultural and linguistic competence with members of the targeted populations.

6. Identify appropriate, trusted messengers to deliver the messages and appropriate channels of delivery.

7. Maintain ongoing relationships and partnerships with community organizations, government agencies, first responders, and other service providers.

8. Expand your existing computer database to include research on communication barriers for functional needs population groups and preferred channels of communication.

9. Create a communication plan to reach functional needs populations using a variety of methods, messages, and messengers. This plan will supplement your existing EOP communications section.

10. Exercise communication plans. Look for gaps in message delivery.

11. Revise functional needs population outreach plans accordingly to the lessons learned from the exercise. Schedule communication exercises at least annually.

12. Expand the initiative to include more functional needs population groups as needed.

D. Individual and Family Preparedness

Everyone should have preparedness, evacuation, and sheltering plans whether an individual or a family. A general rule of thumb is to plan to be self-sufficient for at least three days. Individuals with functional needs should be encouraged to prepare these plans that include provisions for support networks, adaptive equipment, service animals, pets, effective communication, rendezvous components, accessible transportation, medications, food, water, sanitation, and other individual needs. An emergency support network can consist of friends, relatives, or aides who know where the person is, what assistance he or she needs, and who will join the person to assist them in seeking shelter or when sheltering-in-place. If a person's plan depends on assistance from others, it is essential that those others fully understand and commit to their role, and that the individual also establish backup plans as a safeguard against unforeseen contingencies. Some support network members may not be able to reach the person with specific functional needs, so alternatives must be in place. Individual disaster preparedness educational resources are listed in Appendix I.

Encourage self-identification within AHHRs. Prepare and distribute information on voluntary pre-registration of individuals who will need assistance or accommodations during an emergency. Those who need individual notification and/or assistance in order to evacuate their homes and workplaces can register with their local Emergency Management Director (EMD) in advance. Some NH towns and cities have recently launched their own self-identification programs. Ideally such systems should inform responders of a registered individual's communications and assistance needs, as well as indicating where to look for the person if not at their primary address and who else should be contacted on the individual's behalf.

SECTION 2 – RESPONSE

Response is the actual provision of emergency services during an emergency and/or disaster. These activities can reduce casualties, limit damage, and help to speed recovery. Response activities include directing emergency operations, evacuation, shelter and other protective measures. (State EOP)

A. Alert and Notification

Leaders, responders, and community networks need to be trained and well informed about a variety of functional needs concerns; especially alerting and notification. Outreach and networking with functional needs population groups can lend experience in training, how best to alert and notify, and can help meet unexpected resource needs during an emergency. Local emergency response must work with agencies, FBOs, and CBOs serving functional needs populations and informal community leaders to establish emergency communication networks.

It is essential to utilize multiple redundant channels and alternative formats in alerting populations to an emergency. Yet, for cultural and linguistic minorities, readying the optimal channel is a time-intensive task that must be accomplished at the local level prior to an emergency. In addition, it is essential to work with media outlets serving non-English speaking populations (see Appendix H for a brief list).

Composing warning messages, directions, announcements, offers of assistance and other public information accessible to people with communications disabilities requires awareness of different needs, and familiarity with the capabilities and limitations of various communications technologies. Some considerations and strategies for making emergency communications and related announcements accessible to people who are deaf and hard-of-hearing, people who are blind or have low vision, and people with cognitive disabilities are as follows. Additional information is located in Appendix I for these and other functional needs groups.

Deaf and Hard-of-Hearing

- Closed captioning
- Qualified American Sign Language (ASL) interpreters
- "Real time" captioning at public meetings with Communications Access Realtime Translation (CART)

- Reverse electronic notification technology should have the capacity to send text messages to people who have registered as using TeleTYpewriters (TTYs)
- "Notifiers" should be dispatched to knock on doors of persons known to need personal identification and guidance

Blind or Low Vision

- Pre-printed literature in large print
- Electronically displayed information should be formatted for accessibility
- Screen readers (software that reads text aloud through a voice synthesizer) requires some formatting considerations:
  - Post "text only" version of all pages and releases
  - Use graphics and text boxes sparingly, particularly at the top of the page
  - All essential graphics should be described in text

Cognitive Impairments

- Clearly describe, in simple language, the information about the nature of any risks, specific areas affected, and the steps to take
- Pictures, such as universal symbols, should be used whenever possible
- Limit the length of printed and verbal instructions
- Dispatch "notifiers" to knock on doors

B. Evacuation

Not all disasters require individuals to flee their homes or businesses. However, safe and effective evacuation of all people with varying levels of functional need should be a central objective. Planners need to anticipate logistics and communications needs for both evacuation and sheltering scenarios. Issues such as transportation, personal assistance devices, service animals, supplies, equipment, help and support of family members, friends, pets, and/or directly employed aides are important to many people with functional needs. Consider multiple formats for accessible communications when preparing evacuation communications. Allow for flexibility and accommodation beyond what is envisioned.

When preparing to evacuate, people with functional needs need to gather essential information and documentation. For individuals in group homes, resident or day program centers, or other fixed facilities, evacuation kits should be prepared for each person. An evacuation kit and plan for individuals with functional needs should include the following:

Evacuation Kit

- Vital records
- Vial of life
- Assistive technology supplies
- Disability-specific disaster preparedness inventory
- Medications and/or nutritional needs and/or personal care supplies
- Plan for pet or animal care
- List of other specific items

Evacuation Plan Components

- How to evacuate a home or office
- Who to call for transportation
- Where to go
- Who to contact once relocated
- When the shelter closes, where to go, and how to get there

Responders must be trained on the importance of allowing individuals with disabilities to bring personal care assistant or family members, service animals and mobility, communications and medical devices with them. Provisions should be made to assure safe transport of mobility, communications and other assistive equipment. Polices need to reflect an understanding that these supports are not optional.

The rule should be that if a person says it is important for them to bring particular people, animals or equipment with them, they should be allowed to do so unless granting the request would likely result in imminent harm to the person or others.

Exercises to evaluate evacuation plans for fixed facilities, day programs, medical facilities, and large public buildings should be conducted at least once a year. These exercises should include alarm systems and methods to personally notify people who are deaf or who have hearing impairments regarding evacuation warnings; individuals who have visual impairments can independently find their way to exits and safe rallying points.

People with disabilities should not be routinely transported to health care facilities simply because they have disabilities. Triage decisions should be informed by an understanding that there is a difference between living with a disability and needing to be transported to a health care facility because of illness.

Transportation

Functional needs populations are diverse and constantly changing. Information on their location and transportation needs is not always readily available. Legal and social barriers can impede addressing these evacuation challenges. Steps should be taken to include social service and transportation providers and transportation planning organizations in determining transportation needs and develop agreements for emergency use of drivers and vehicles. Once plans are established, training opportunities should be determined. Lastly, exercises should be conducted to identify additional challenges posed by evacuating hospitals, fixed facilities, and individuals with varying functional needs. In December 2006, the Government Accountability Office published its' findings on challenges and barriers faced by federal and State emergency officials available at http://www.gao.gov/new.items/d0744.pdf. One major recommendation stated that DHS should require state and local evacuation preparedness for transportation of disadvantaged populations and improve information to assist these governments.

Communities should work together to coordinate evacuation plans in advance. Many people with disabilities do not drive and routinely use public para-transit systems operated by public transit (Dial-a-Ride, ADA Transit) and may call on such services before, during, and after an emergency. If these services are unavailable during the emergency, plans must include a way to forward requests to emergency services or transportation coordinators and to alert customers that the request has been forwarded. If long-term care facilities have contracted for accessible evacuation transportation, they must not all plan to use the same contractor, or if they do, they must be sure that the contractors have sufficient vehicles to meet all needs.

The regional coordinated plans required to be available in all NH planning regions area a good source for listings of transportation operators and their capacities, including vehicle accessibility, age, mileage, and driver availability. Emergency response coordination should be included in the coordinated transportation planning efforts undertaken by the regional planning commissions with funding from NH Department of Transportation (DOT).

Vans and buses vary as to the number of individuals they can accommodate and the types of lifts, ramps and wheelchair securing devices they employ. The process of inventorying these vehicles should identify overall occupant capacity and whether there are any limitations regarding the size or type of wheelchairs or other equipment they can safely transport. Operators need to be trained in the safe operation of lifts, ramps, tie downs and other mechanical devices and in safety issues.

Planners should also consult with ESF liaisons for Communications and Alerting, Mass Care & Shelter, Health & Medical Services, Public Information, Volunteers & Donations, and Animal Health when developing evacuation plans.

C. Sheltering

State and local emergency management have the responsibility for designating and coordinating shelters during times of an emergency or a disaster. The management, operation, and staffing of the shelter is the shared responsibility of local and State Emergency Management, ESF primary and supporting agencies for Public Works & Engineering, Mass Care, Health & Medical Services, Food & Water, Public Information, Volunteers & Donations, and Animal Health.

To the maximum extent possible, shelter and support plans should include persons with functional needs along with others in their community and the co-location of a shelter for pets. Each AHHR should outreach to community-based organizations that service functional needs populations within their communities regarding shelter planning. The following action steps were adopted from the Americans with Disabilities Act (ADA) *An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities* and should be considered:

1. Accessible Shelters: All congregate shelters should be assessed for physical accessibility and suitability to accommodate people with disabilities. Survey your community's shelters for barriers to access for persons with functional needs. If you find barriers to access, work with the facility's owner to try to get the barriers removed.

2. Input on Shelter Planning and Staff Training: Invite representatives of functional needs populations to meet for shelter planning. Discuss with them which shelters they would be more likely to use in the event of an emergency and what, if any, disability-related concerns they may have while sheltering. Develop site-specific instructions for your volunteers and staff to address these concerns. Trained, knowledgeable surveyors, including people who use accessible features, should evaluate basic physical accessibility of facilities. People who use wheelchairs and other mobility devices should be able to enter and leave safely and independently, use bathroom facilities, including showers, and have internal access to

essential features such as food service, administrative and communications areas, sleeping areas, first aid stations, and emergency exits. The assessment should also look for situations that are potentially unsafe for individuals with visual and mobility impairments or unhealthy for people with sensitivities to environmental conditions (mold/other allergens, environmental pollutants, excessive hot or cold conditions). Remember that temporary solutions are available, such as portable ramps, TTY equipment, and portable privacy screens.

3. Service Animals: Adopt procedures to ensure that people with functional needs who use service animals are not separated from their service animals when sheltering during an emergency, even if pets are normally prohibited in shelters. While you cannot unnecessarily segregate persons who use service animals from others, you may consider the potential presence of persons who, for safety or health reasons, should not be with certain types of animals.

4. Medications, Refrigeration, and Back-up Power: Ensure that a reasonable number of emergency shelters have back-up generators and a way to keep medication refrigerated. The public should be routinely notified about the location of these shelters.

5. Communications: Accessible communication is critical in a shelter. Adopt procedures to provide accessible communication for people who are deaf or hard of hearing, have severe speech disabilities, visual disabilities, or are non-English speaking. Train staff on the basic procedures for providing accessible communication. Internal public announcement systems may not be effective in informing shelter occupants who are deaf or hard of hearing. Printed signage may not be of use to occupants who are blind or visually impaired. Complicated and lengthy forms may be inaccessible to people with cognitive impairments without assistance.

Congregate Care Facilities

The American Red Cross (ARC) congregate care facilities, commonly called "shelters", have traditionally been classified by type and level of service. As a result of the 2005 hurricane season a new strategy has been implemented by the ARC to address issues of diversity, hard to reach populations, as well as the integration of untapped community resources and knowledge provided by partner agencies. The Red Cross cannot be everywhere at once. Additionally, many community organizations want to serve their communities in a broader way and look to the ARC as a resource to help them do so effectively. Community partnerships provide the best possible response and service to improve the community's overall system of disaster response.

The National Response Plan (NRP) has outlined specific responsibilities for the ARC regarding shelters. In particular, all ARC agencies are to register the activation of their shelters in the National Shelter Database and supply daily shelter populations and other information regarding their activities. The National Shelter Database is currently under development.

In line with this responsibility, the ARC has developed a framework of four sheltering relationships or "models," including the traditional ARC shelter model.

- **Model 1 – Red Cross Shelters**: The ARC occupies a facility, plans, organizes, directs and controls every aspect of the Red Cross services provided at the shelter. The Red Cross and the facility owner sign the standard Red Cross shelter agreement entitled *Agreement to Permit the Use of a Facility as a Red Cross Emergency Shelter*. Liability is shared by the Red Cross and the facility owner based on their respective responsibilities regarding the facility, and will be apportioned based upon the particular circumstances surrounding an incident during a Red Cross shelter operation.

- **Model 2 – Red Cross/Partner Shelters**: The standard facility agreement is used. The primary difference is that the majority of the volunteer staffing will come from the partner agency personnel and will not be assigned by the Red Cross. Training will be provided by the Red Cross to the volunteer staff. The Red Cross will have administrative control of the shelter.

- **Model 3 – Red Cross Supported Shelters**: The community agency assumes responsibility for planning, organizing, directing and controlling every aspect of the shelter and the relief services provided. These community agency shelters will display a "Supported by the Red Cross" designation, and abide by the Red Cross Disaster Code of Conduct of service delivery.

- **Model 4 – Independently Managed Shelters**: Managed by community agencies that have determined that they 1) want to retain administrative control of the activities related to the provision of shelter, 2) do not wish to abide by the Red Cross Disaster Code of Conduct and/or 3) may not want to be supported by the Red Cross.

Community officials should review agreements and administrative policies with shelter operators to ensure practices do not discriminate on the basis of disability. Municipal authorities and their attorneys should review agreements with shelter operators to ensure conformance with Title II of the ADA and Section 504 of the Rehabilitation Act. Shelter operators' policies on accommodation should be reviewed to ensure that managers have the flexibility and are affirmatively directed to reasonably modify rules and practices in response to identified needs of individuals with disabilities. It is important that decisions about accommodation be made on the basis of the ability to meet a resident's needs, and not simply on the basis of disability or diagnosis. Administrative polices should affirmatively include provisions for disability or other human service agencies to visit and assist individuals with functional needs.

Temporary Medical Infirmary

Community emergency planners should be aware that some shelter operators are not staffed to provide care for individuals with significant health care needs. Planners should become familiar with the policies and procedures of shelter operators in their communities, and should make plans to accommodate individuals whose needs are greater than can be met in a general population congregate care facility. Such individuals require limited medical/nursing oversight that cannot be provided in a general population shelter. Medical eligibility is based on a system that takes into account the acuity of the condition and skills and equipment required to provide

care. For example, most ARC shelter cots are low-off-the-floor and some people may not be able to get into or out of the cots.

Individuals who may need to go to a temporary medical infirmary may be people with:

- Significant mobility issues
- Require significant physical assistance
- Have a chronic or debilitating condition that are unable to tolerate noise, confusion, lack of privacy and/or lack of personal care
- Require medical care, treatment or monitoring
- Require care, treatment or monitoring of a surgical condition
- Have mental or emotional needs
- Who reside in their own homes on a day to day basis but can only do so with significant in-home care

A temporary medical infirmary can be designated as an alternate care site (ACS) provided that patients/clients do not require artificial ventilation management. As described in Appendix C, Glossary of this document, an ACS is a community-based facility established to provide medical care and allocation of scarce equipment, supplies, and personnel. ACSs are ideally located in buildings of opportunity in close proximity to an acute care hospital.

It should be recognized that individuals needing medical care may arrive for shelter as part of a family unit, and that it may be best for the individual and for the family to be accommodated in close proximity. Should it be necessary to plan for an ACS/temporary medical infirmary, co-location with a general congregate care facility may accomplish this goal. If this is not possible, sheltering of the family as part of the temporary medical infirmary may be desirable.

Co-location or near-location of a temporary infirmary with a general congregate care facility may be desirable for many reasons, including care assistance from family members and the ability of those operating general care facilities to support some of the needs of the temporary infirmary, including feeding assistance and the provision of comfort items. In making plans to locate a temporary infirmary, it may be beneficial to make contact with the American Red Cross or any other operator of general congregate care facilities, to learn of all of the facilities in the community for which they have or can make arrangements. These are not always public buildings. Appropriate facilities may not be apparent to local emergency planners. Conversely, emergency planners may be able to suggest appropriate facilities for co-location.

Disasters such as floods and hurricanes, may result in an inability for individuals with functional needs to safely return home. Damages can leave persons displaced, in need of shelter, food and support services either temporarily or long-term. Planners of ACSs/temporary medical infirmaries should establish alternate site discharge planning response teams. These teams are activated to provide resource and logistical support to local jurisdictions ACSs/temporary medical infirmaries to assist with discharge planning and transition of clients to appropriate services and resources within the community. More information on alternate site discharge planning for temporary medical infirmaries is available at www.doh.state.fl.us/PHNursing.

Temporary medical facilities cannot, and will not, be operated and managed by the American Red Cross. Only in a catastrophic event, one totally overwhelming the health care system, and only as a matter of last resort, would this ARC position change.

Emergency Temporary Relocation of an Acute and/or Chronic Medical and other Fixed Facilities

Disasters and other emergencies may require the relocation of fixed facilities such as, hospitals, nursing homes, assisted living or other residential facilities. Such a facility is not open to the public and is, in essence, simply a transfer of the patient/resident setting from one location to another. Ideally, fixed facilities should have at a minimum two plans in place:

- **Plan A**: An alternate fixed facility site to which they can transfer patients/clients/incarcerated en mass or alternative agreements for acceptance of a number of individuals by other facilities of similar type in another location.

- **Plan B**: In the absence of ability to activate Plan A, the facility will have identified both alternate sites that they themselves can open as temporary facilities and have trained their staff to activate, open and manage such a temporary facility.

Emergency Relocation of an Acute and/or Chronic Care Medical Facility or other Fixed Facility is never the responsibility of the American Red Cross and the role of the American Red Cross, operationally, is and should be extremely limited.

Animal Shelters

Planning for, and implementation of, animal evacuations/rescue, sheltering and reunification follows most of the same tenets as planning for, and implementation of, human evacuations/rescue, sheltering and reunification. Pending approval mid-2007, the NH *Animals in Disaster Resource Directory* will provide information to assist towns, cities and State emergency preparedness planners with disaster animal management. Specific inclusions deal with co-sheltering versus separate shelter availability versus pet-friendly hotels. The benefit of co-located shelters is that pet owners can provide the labor and often supplies for their own pets, minimizing the need for the town/state to provide personnel and resources which may be better deployed elsewhere. There are over 70 licensed animal shelters/rescues in NH including several with the Society for the Prevention of Cruelty to Animals (SPCA). Municipal authorities and their attorneys should review agreements with shelter operators regarding animal sheltering and where possible, modify rules and practices in response to pet owners.

Sheltering of Criminal Offenders

In the event that correctional facilities would need to evacuate, inmates would be sheltered at other NH State and County correctional facilities. However, collaborative dialogue is needed with County and State Correctional officials and local and regional emergency planners to assist with planning for individuals on parole, under investigation, or are known criminal offenders that may come to a shelter or infirmary.

Reverse Evacuation

Evacuation will not always be possible or desirable in an emergency, and people with functional needs must also prepare to shelter where they are at. Local plans should include ways to check on people and get personal care assistance to those who need it. Individual needs vary, but during a prolonged emergency, some individuals will need assistance from others in meeting their basic needs. Plans should call for linkages with community-based organizations, home care, and other agencies for assistance. Provide clear instructions for people who are sheltering to request assistance.

Shelter-in-Place

Although construction and operation of nuclear power plants are closely monitored and regulated by the Nuclear Regulatory Commission (NRC), accidents are possible. In the event of an accident, there could be a release of dangers levels of radiation. Local emergency management authorities would instruct the public through the Emergency Alert System (EAS) on local television and radio stations. However, some individuals may need specialized assistance. As discussed in Section 1 – Preparedness, efforts to encourage individuals with functional needs to self-identify should be promoted.

SECTION 3 – RECOVERY

Recovery is both a short-term and a long-term process to restore the jurisdiction to normal conditions in the aftermath of any emergency or disaster involving extensive damage. Short-term operations assess damages, restore vital services to the community and provide for basic needs to the public. Long-term recovery focuses on restoring the community to its normal, or to an improved, state of affairs. Examples of recovery actions are provision of temporary housing, restoration of government services and reconstruction of damaged areas. (State EOP)

The recovery phase of an emergency typically is the longest and most difficult aspect of a disaster for a community's residents, and this can be especially traumatic for people with functional needs. They may be deprived of vital connections to attendants, guide animals, neighbors, and local business owners, and even family members. They may no longer be able to follow their accustomed routines. There may also be evidence of psychological distress by forcing some individuals with functional needs to confront their limitations or to relive traumatic experiences from their past.

Emergency planners, of course, can do little to counter some of these effects, such as psychological distress and changed community environments. However, plans can be established so that those services and functional needs most critical are restored or addressed as a priority during the recovery phase. The following considerations are modified from the *N.O.D. Guide on the Special Needs of People with Disabilities for Emergency Managers, Planners & Responders*:

- Making allowances at blockades, shelters, and other impacted areas for access by attendants, home health aids, visiting nurses, interpreters, guide animals, and other individuals crucial to immediate functional needs of individuals,
- Identifying the impact on the disability community of an interruption in utility services,
- Planning for accessible shelter and appropriate temporary housing needs,
- Addressing how people with functional needs who are employed by businesses that are able to open soon after a disaster will get to work, and
- Involving representatives of the functional needs community in "after action reviews" or "hot wash reports" in order to capture the true impact of the disaster and to improve plans for the future.

Short-Term Recovery

Short-term recovery focuses on restoring vital utilities and life support systems (e.g., power, water, sanitation, and communications), transportation infrastructure, the removal of debris, and the assessment of damage. Coordinating and restoring vital services for individuals with functional needs requires developing post-disaster recovery and reconstruction plans with agencies and organizations that serve them and highlighting their most essential objectives. Try to identify in advance those decisions that will need to be made after a disaster that are most likely to have long-term repercussions for hazard mitigation in communities with functional needs populations.

The central element of good decision making in the short-term recovery period following a disaster is the community's designation of a recovery management team that is empowered to monitor the process and implement the community's post-disaster recovery policies.

Re-Entry/Return to Residential Areas

This process will require a collaboration of community service organizations, emergency responders, shelter managers, and possibly State guardianship agencies.

Long-Term Recovery

Long-term recovery planning involves identifying strategic priorities for: restoration, improvement, and growth. Involving individuals with functional needs and representatives of agencies/organizations that serve them is critical in enhancing the quality and breadth of input into decision making during this crucial period.

Following certain disaster events, state and local governments may wish to undertake a long-term recovery program in which FEMA supplemental federal support is not required. The *FEMA Long-Term Community Recovery (LTCR) Self-Help Guide* is intended to provide state and local governments with a planning framework for implementing their own long-term community recovery planning process. Ideally as part of preparedness, state and local governments should start putting into place infrastructure to support a LTCR program before a disaster occurs.

Coordination/Restoration of Services (medications, durable medical equipment (DME), etc.

Establishing memorandums of agreement (MOAs) pre-disaster with vendors that provide services or goods to individuals with functional needs in communities will help to establish levels of coordination and restoration. Additional areas of priority for integrating functional needs populations issues into emergency plans currently under review at the federal level but are relevant to this Guidance include:

1. Public and private insurance programs access to prescription drugs and limits on the supply of these drugs.

2. Assurances that Medicaid waivers that allow for state-to-state services are part of emergency plans, (Restriction in the Medicaid program for community-based services prevents proper referral and care for people with disabilities.)

3. Medicaid reimbursement funds should follow the person, agency-to-agency and state-to-state.

4. Funding to develop accessible temporary and long-term housing post disasters.

Appendix A:

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Appendix A

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Appendix B:

ACRONYMS

Appendix B

ACS	Alternate Care Sites
ADA	Americans with Disabilities Act
AHHR	All Health Hazards Region
ANI/ALI	Automatic Number Identification / Automatic Locator Information
ARC	American Red Cross
ASL	American Sign Language
BEM	Bureau of Emergency Management, now called the Department of Safety Homeland Security and Emergency Management
CAP	Community Action Program
CART	Communications Access Realtime Translation
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention, Atlanta GA
CERT	Community Emergency Response Team
DBHRT	Disaster Behavioral Health Response Team
DHS	Department of Homeland Security, US
DME	Durable Medical Equipment
DOT	Department of Transportation
EAS	Emergency Alert System
EMAC	Emergency Management Assistant Compact
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESAR-VHP	Emergency Systems for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function

FBO	Faith-Based Organization
FCC	Federal Communications Commission
FBO	Faith-Based Organization
FEMA	Federal Emergency Management Agency
GIS	Geographical Information Systems
HB	House Bill
HIPAA	Health Insurance Portability and Accountability Act
HSEM	Homeland Security and Emergency Management, DOS-NH
IC	Incident Command
LTCR	Long-Term Community Recovery
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MOP	Metropolitan Planning Organization
MRC	Medical Reserve Corps
NGO	Non-Governmental Organization
NH	New Hampshire
NH DHHS	New Hampshire Department of Health and Human Services
NH EOP	New Hampshire Emergency Operations Plan
NIMS	National Incident Management System
NNE MMRS MST	Northern New England Metropolitan Medical Response System Medical Strike Team
NOD	National Organization on Disability
NRC	Nuclear Regulatory Commission
NRP	National Response Plan

RERP	Radiological Emergency Response Preparedness/Plan
RSA	Revised Statutes Annotated
SPCA	Society for the Prevention of Cruelty to Animals
TDD	Telecommunications Device for the Deaf
TTY	TeleTYpewriter
US	United States
VOAD	Volunteer Organizations Active in Disasters

Appendix C:

GLOSSARY

Appendix C

Please note that the following definitions were selected by the NH Functional Needs Guidance Committee, but may occasionally deviate from other documents, including other state planning documents.

Alternate Care Sites

An alternate care site (ACS) is a community-based facility established to provide care and allocation of scarce equipment, supplies, and personnel. ACSs are ideally located in close proximity to an acute care hospital. ACSs will not manage critical care concerns, such as persons requiring artificial ventilation.

Acuity

The severity of a person's illness and the level of attention or service the person will need from professional medical staff.

All Health Hazards Regions (AHHRs)

The New Hampshire Department of Health and Human Services (NH DHHS) and the Pandemic Planning Coordinating Committee divided the State of New Hampshire into 19 geographical regions for the purpose of all health hazards public health emergency planning. The regions are largely consistent with hospital service areas but may deviate based on healthcare delivery systems, economic ties, school systems, and daily living patterns of residents.

Capability

The ability to appropriately use human and physical resources in an event.

Capacity

The most efficient level of human and physical resources in an event.

Community-Based Organizations (CBOs)

These are local organizations (which may or may not be an affiliate of a national organization) with a primary mission to provide services to specific groups or people. CBOs are usually nonprofit organizations. Most have a 501 (c) (3) tax-exempt status from the Internal Revenue Service. Some may have the nonprofit status granted by the Franchise Tax Board. In size, they range from all-volunteer organizations that get by on virtually no budget, to multi-million dollar operations. Examples include Food Banks, centers for independent living, Immigrant Assistance Programs, Faith-Based Organizations (FBOs), Community Action Programs (CAPs). For more information on CBOs in emergency planning, a resource guide, "*Meeting the Needs of*

Vulnerable People in Times of Disaster: A Guide for Emergency Managers" was developed by the California Governor's Office of Emergency Services is available at:

http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Vulnerable%20Populations/$file/Vulnerable%20Populations.PDF

Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

A database of medical and non-medical volunteers created under a national initiative supported in each state to address the need for healthcare volunteers in emergencies.

Functional Needs Populations

A collective category that includes, but is not limited to, the following:

Isolated Groups	Medical	Other Considerations	
• Culturally • Geographically • Limited English Proficiency • Socio-Economically	• Blind or Visually Impaired • Chronic Conditions • Cognitive Impairments • Deaf or Hard-of-Hearing • Emotional Impairments • Medically Dependent • Pharmacologically Dependent • Physical Limitations	• Adult Care Givers • Children • Day Program Settings • Frail Elderly • Homebound • Homeless • Immigrants • No Transportation • Pregnant • Refugees • Schools (primary, secondary, post-secondary) • Seasonal Camps • Single-Parents • Tourists	• Residential Settings: o Correctional o Group or Community Residences o Half-way Houses o Hospice o Hospitals o Nursing Homes o Orphanages o Religious Orders

Geographical Information Systems (GIS)

A system for management, analysis, and display of geographic knowledge, which is represented using a series of information sets such as maps and globes, geographical data sets, processing and work flow models, data models, and metadata. For more information on GIS mapping software, link to:
http://www.esri.com/industries.html

Medical Surge

Disasters or emergencies that result in numerous persons requiring medical treatment that surpass the normal resource capacity and/or capability of a community.

Special Populations

According to the FEMA, special populations are “individuals unable to respond in their usual manner during an emergency”.

TTY/TDD

Personal assistance devices for Deaf and hard-of-hearing, TeleTYpewriter or Telecommunications Device for the Deaf.

Triage

The sorting of individuals into groups according to their need and resources available.

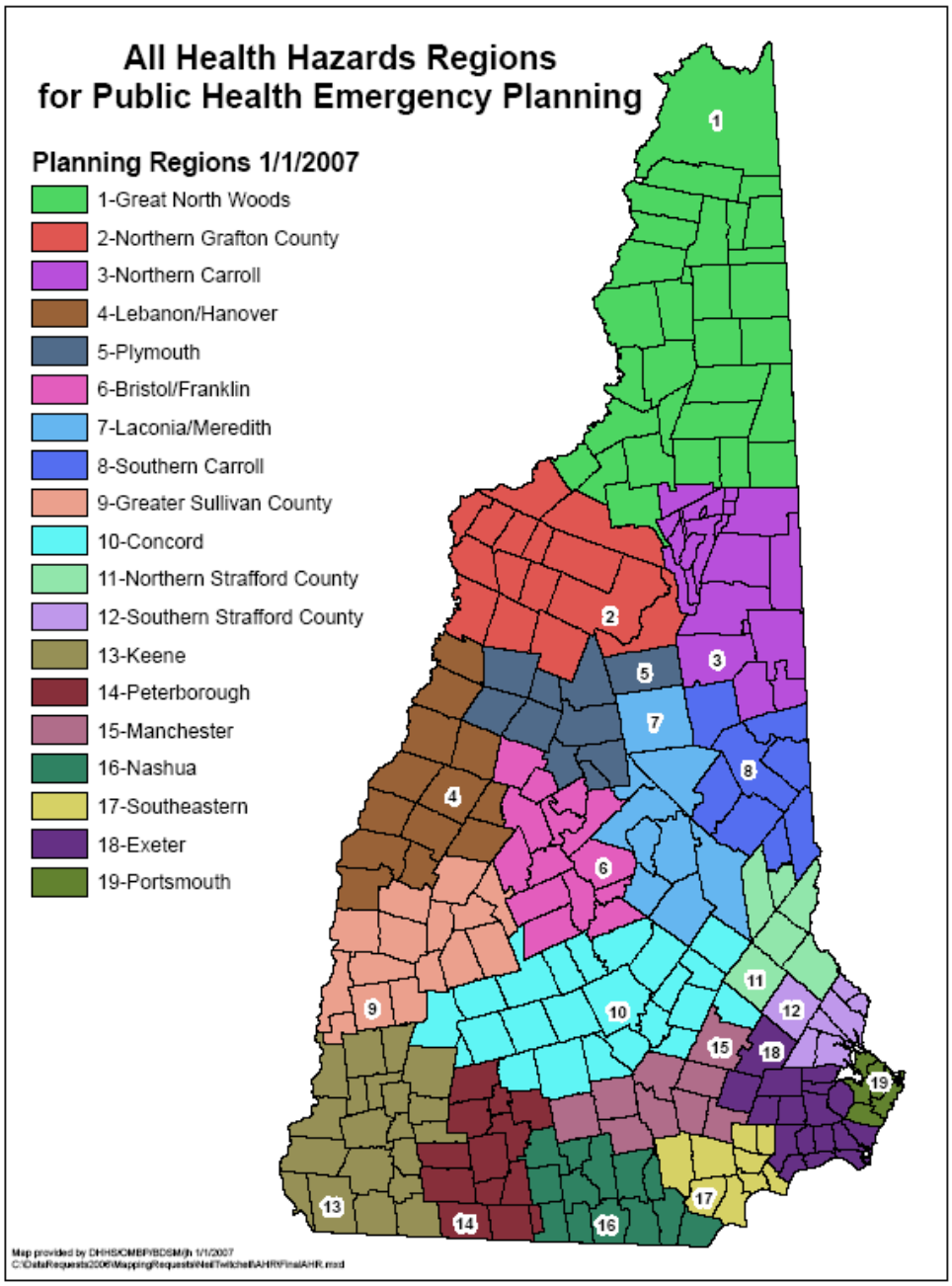
Vial-of-Life

Medical history, current medication list, and emergency contact information That is contained in a vial. The form can be downloaded at www.vialoflife.com

Appendix D:

ALL HEALTH HAZARDS REGIONAL MAP

Appendix D


All Health Hazards Regions
for Public Health Emergency Planning
Planning Regions 1/1/2007
1-Great North Woods
2-Northern Grafton County
3-Northern Carroll
4-Lebanon/Hanover
5-Plymouth
6-Bristol/Franklin
7-Laconia/Meredith
8-Southern Carroll
9-Greater Sullivan County
10-Concord
11-Northern Strafford County
12-Southern Strafford County
13-Keene
14-Peterborough
15-Manchester
16-Nashua
17-Southeastern
18-Exeter
19-Portsmouth

Appendix E

AUTHORITIES

Appendix E

Statute	Agency	Authority
US Public Law 93-288	Federal government	Provides authority to respond to emergencies and provide assistance to protect public health; implemented by Federal Emergency Management Act
1973 Rehabilitation Act, Section 504	Federal government	Prohibits federal agencies and federally funded programs from discriminating on the basis of disability. Section 504 applies to a number of entities and federally funded activities not reached by the Americans with Disabilities Act (ADA).
Title VI of the 1964 Civil Rights Act	Federal government	Protects individuals from discrimination on the basis of their race, color, or national origin in programs that receive federal financial assistance.
The Americans with Disabilities Act, July 26, 1990	Federal government	The Americans with Disabilities Act (ADA) is a comprehensive civil rights law for people with disabilities. The Department of Justice enforces the ADA's requirements in three areas: 1) Title I: Employment by units of State and local government, 2) Title II: Programs, services, and activities of State and local government, and 3) Title III: Public accommodations and commercial facilities.
Robert T. Stafford Emergency Management and Disaster Assistance Act, Section 308	Federal government	Prohibits discrimination on the basis of race, color, religion, nationality, sex, age, or economic status in all disaster assistance programs.
Pets Evacuation and Transportation Standards (PETS) Act, H.R. 3858, August 4, 2006	Federal government	This Act is which an amendment to the Staffords Act, Robert T. Stafford Disaster Relief and Disaster Assistance Act (42 U.S.C. 5121 et seq.) requires FEMA to ensure state and local disaster preparedness plans "take into account the needs of individuals with household pets and service animals prior to, during, and following a major disaster or emergency."
Federal Communications Commission (FCC), Closed Captioning, 2006	Federal government	Requires 100 percent of new, non-exempt English language programming on television stations to be closed captioned. Stations giving out emergency information in their audio make that information available simultaneously to the hearing impaired during breaking news situations.
Federal Communications Commission (FCC), Video Description Rules, 2000 and 2001	Federal government	Audio descriptions are integrated into natural pauses to describe the actions that are happening in the visual part of a program. The largest broadcast television stations and multi-channel video programming distributors are to provide a limited amount of video description.

Statute	Agency	Authority
Federal Communications Commission (FCC), Information and Referral 2-1-1, 2000	Federal government	The intent of this number is to assist "the elderly, the disabled, those who do not speak English, those who are having a personal crisis, the illiterate, or those who are new to their communities, among others, by providing referrals to, and information about health and human service organizations and agencies. This number is a possible available resource for communication in disaster situations as well.
RSA 21-P: Department of Safety	Governor HSEM	Allows Governor to delegate authority to HSEM Director to carry out necessary functions to preserve lives of the people of NH during an emergency
RSA 4: Powers of the Governor and Council	Governor	Allows Governor to declare a state of emergency as that term is defined in RSA 21-P: 35, VIII Gives Governor direction and control of emergency management (see RSA 4:45, 4:46 & 4:47)
RSA 141-C: Communicable Disease	DHHS	Authorizes the DHHS to purchase and distribute pharmaceutical agents to prevent the acquisition and spread of communicable disease Authorizes the DHHS to adopt rules to distribute prescription pharmaceuticals in public clinics Establishes a vaccine purchase fund for the purchase of antitoxins, serums, vaccines and immunizing agents Allows DHHS to issue complaint to an individual and seek assistance of law enforcement; allows law enforcement officials to take an individual into custody and transport him/her to the place where he/she can be isolated, quarantined or treated; allows due process for such individuals (the right to a superior court hearing)
RSA 126-A:19	DHHS	Provides authority for a statewide program of community living facilities for persons with developmental disabilities or in need of behavioral health services.
RSA 126-A:26	DHHS	Provides authority for an emergency shelter program to assist in providing safe and sanitary shelters on a short-term emergency or transitional basis for persons who are destitute, mentally ill, abandoned, or developmentally disabled, and other poor persons.

Statute	Agency	Authority
RSA 151	DHHS	Provides authority for the development, establishment and enforcement of basic standards for the care and treatment of persons in hospitals and other facilities in which medical, nursing or other remedial care are rendered, and for the construction, maintenance and operation of such facilities.
RSA 541-A: Administrative Procedure Act	State Agencies	Allows State agencies to adopt emergency rules when there is imminent peril to public health or safety, without going through normal rule making process; see also RSA 4:47, III which allows the Governor to make, amend, suspend or rescind orders, rules and regulations during a state of emergency.
RSA 508:17-a	DHHS, DOS	Provides important protections for persons who are designated to act as agents of the State during a public health or public safety incident.
RSA 21-P:37 of HB 1435	DOS	This bill authorizes the director of the division of emergency services, communications, and management to prepare a plan for service animals to be evacuated in the event of an emergency. The bill states that in cases of emergency it is state policy that service animals not be separated from the persons they serve. This bill also establishes a commission to study the evacuation and housing of animals in case of an emergency.

Appendix F

LIMITED LIABILITY FOR AGENTS ASSISTING CERTAIN STATE DEPARTMENTS

Appendix F

TITLE LII
ACTIONS, PROCESS, AND SERVICE OF PROCESS

CHAPTER 508
LIMITATION OF ACTIONS

Section 508:17-a

508:17-a Agents Assisting Certain State Departments; Liability Limited. –

I. Any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident shall be protected from claims and civil actions arising from acts committed within the scope of his or her official duty as an agent to such departments to the same extent as state officers, trustees, officials, employees, and members of the general court under RSA 99-D, provided that:

(a) The commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing to the governor that a public health or public safety incident exists;

(b) The department of health and human services or the department of safety has designated the person to act as its agent to assist in responding to the public health or public safety incident;

(c) The agent was acting in good faith and within the scope of his or her official functions and duties as an agent to the department of health and human services or the department of safety; and

(d) The damage or injury was not caused by willful, wanton, or grossly negligent misconduct by the agent.

II. In this section:

(a) "Agent" means any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident and the person does not receive compensation from either department, other than possible reimbursement for expenses actually incurred for such services, but who may be receiving compensation from his or her employer or from any other source.

(b) "Damage or injury" includes physical, nonphysical, economic and non-economic damage, and property damage.

(c) "Public health or public safety incident" means a specific incident that the commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing poses a threat to the health and safety of the public and demands a response that will require the assistance of agents from outside the state system, but which does not rise to the level that would necessitate the declaration of a state of emergency by the governor under RSA 4:45.

III. Notwithstanding any other provision of law, no person shall be considered an agent of the department of health and human services or the department of safety for the purposes of this section unless the commissioner of one of those 2 departments has declared in writing to the governor that a public health or public safety incident exists and the appropriate department

acknowledges in writing the person's status as an agent. Such written acknowledgment shall identify the person, indicate the department of the state for which the person will be acting as an agent, indicate the duration for which the person will be acting as an agent, indicate the functions that the person will be performing for the appropriate department, and specifically indicate that the provisions of this section apply to the person's status as an agent to the appropriate department.

IV. Any licensed health care provider who acts as an agent to the department of Health and Human Services by providing health care or services in response to a public health incident shall work under the oversight of a department physician.

V. No disciplinary action shall be taken by a licensing board against a licensed health care provider who acted as an agent or a volunteer to the department of Health and Human Services or the department of safety. This paragraph shall apply only to a health care provider who was designated by either the department of health and human services or the department of safety to act as an agent in accordance with paragraph III and who acted in good faith within the scope of his or her official functions and duties as an agent, and who did not engage in willful, wanton, or grossly negligent conduct in the course of carrying out his or her official functions and duties.

Source. 2005, 191:5, eff. Jan. 1, 2006.

HB 618 FACT SHEET

During the last legislative session the House and Senate passed, and the Governor signed, HB 618. HB 618 did several things. First it created a new statutory provision, RSA 508:17-a. This statutory provision authorizes the Commissioner of the Department of Health and Human Services or the Commissioner of the Department of Safety to declare a public health or public safety incident. Under that statute "public health or public safety incident" is defined as:

> **"A specific incident that the commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing poses a threat to the health and safety of the public and demands a response that will require the assistance of agents from outside the state system, but which does not rise to the level that would necessitate the declaration of a state of emergency by the governor under RSA 4:45."**

RSA 508:17-a further allows the two Commissioners to seek the assistance of agents to assist in response to the specific public health or public safety incident. Under the statute "agent is defined as:

> **"Any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident and the person does not receive compensation from either department, other than possible reimbursement for expenses actually incurred for such services, but who may be receiving compensation from his or her employer or from any other source."**

Under RSA 508:17-a, any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident will be protected from claims and civil actions arising from acts committed within the scope of his or her official duty as an agent to such departments to the same extent as state officers, trustees, officials, employees, and members of the general court under RSA 99-D. This protection from liability will only be in effect when:

- One of the two Commissioners identified above has declared in writing that a public health or public safety incident exists;
- Either DHHS or DOS has specifically designated the person in writing to act as its agent to assist in responding to the public health or public safety incident;
- The agent was acting in good faith and within the scope of his or her official functions and duties as an agent to the department of health and human services or the department of safety; and
- The damage or injury was not caused by willful, wanton, or grossly negligent misconduct by the agent.

In addition, under RSA 508:17-a, no disciplinary action may be taken by a licensing board against a licensee who acts as an agent in accordance with the provisions set forth above so long as the licensee acted within the scope of his or her official functions and duties as an agent and so long as the licensee did not engage in conduct that was willful, wanton, or grossly negligent.

HB 618 also amended the workers' compensation statute (RSA 281-A) to clarify that if a person is injured while acting as an agent in accordance with the provisions set forth in RSA 508:17-a, the State of New Hampshire and not the agent's regular employer will bear the cost of workers' compensation. In effect, the agent will be considered an employee of the State of New Hampshire for the purposes of workers' compensation.

HB 618 took effect on January 1, 2006.

Appendix G

HIPAA PRIVACY: DURING AN EMERGENCY

Appendix G

Can health care information be shared in a severe disaster? Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:

TREATMENT:

Health care providers can share patient information as necessary to provide treatment.

Treatment Includes:

- Sharing information with other providers (including hospitals and clinics)
- Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services). Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION:

Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care, or the individual's location, general condition, or death. The health care provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest. Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

IMMINENT DANGER:

Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

FACILITY DIRECTORY:

Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.

Source: United States Department of Health and Human Services
http://www.hhs.gov/ocr/hipaa/emergencyPPR.html. Retrieved 9/1/2006.

Appendix H

MEDIA OUTLETS SERVING NON-ENGLISH SPEAKING POPULATIONS IN NH

Appendix H

Radio

Coasta Eagle Broadcasting
462 Merrimack Street
Methuen, MA 01844
(Parent company for two radio stations serving southern New Hampshire)

http://www.coastaeagleradio.com/contactcostaeagle.html
Main Numbers (connecting all stations)
Phone: (978) 683-7171
Fax: (978) 687-1180

Print

EL MUNDO
408 S. Huntington Ave.
Boston, MA 02103

http://www.elmundoboston.com
E-mail: Gabriela@elmundoboston.com

RUMBO
315 Mt. Vernon Street
Lawrence, MA 01843

Phone: (978) 794-5360
Fax: (978) 975-7922
E-mail: dailiadiaz@rumbonews.com or albertosuris@rumbonews.com

SIGLO 21 (XXI)
335 Common Street,
Lawrence, MA 01840

http://www.siglo21.com
Phone: 1-800-836-0272
Fax: (978) 687-1569
E-mail: mail@siglo21.com

Latino News
335 Common Street,
Lawrence, MA 01840

Phone: (978) 557-9977
Fax: (978) 557-9417
E-mail: info@weblatinonews.com

Nos Ostros: Us
Robert Santiago
Manchester, NH

E-mail: rantiago@nosotrosus.com

Television

Latinos Unidos of NH
(every Friday at 6:00pm)
Channel 23 Public Access Channel for Manchester
Daniel Arellano
Vice President, LUNH

http://www.latinosunidosnh.org

Appendix I

NH FUNCTIONAL NEEDS POPULATIONS DIRECTORY OF STATE AND FEDERAL RESOURCES

Appendix I

Effective Communication

Removing Barriers: Planning Meetings that are Accessible to all Participants
http://www.fpg.unc.edu/%7Encodh/pdfs/MeetingGuide.pdf

Tips and Strategies to Promote Accessible Communication
http://www.fpg.unc.edu/~ncodh/pdfs/rbtipsandstrategies.pdf

Resources for use of TTY and Relay Systems
http://www.tdi-online.org/ebb/storeproducts.asp

Translation Services:

Language Bank http://www.thelanguagebank.org

Language Line http://www.languageline.com

Rosetta Stone Associates, Inc. http://www.mv.com/biz/rosetta/

Southern NH Area Health Education Center (AHEC) http://www.snhahec.org

Preparedness

New Hampshire Emergency Preparedness Resources
http://www.nod.org/EPIResources/newhampshire.html

Lutheran Services of Northern New England **– Refugee Settlement Program**
http://www.lssnorth.org/interfaithrefugee.html – 603-224-8111

Disaster Resources for People with Disabilities and Emergency Managers – June Isaacson Kailes; http://www.jik.com/disaster.html

Assisting People with Disabilities - Tips for First Responders **– 2nd Edition**
http://cdd.unm.edu/products/tips_web020205.pdf

A Guide for Including People with Disabilities in Disaster Preparedness Planning – UConn Health Center – A. J. Pappanikou Center for Excellence in Developmental Disabilities Education, Research and Service
http://www.uconnucedd.org/pdfs/Guide%20for%20Including%20People%20with%20Disabilities%20in%20Disaster%20Preparedness%20Planning.pdf

Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency
Four-page summary: http://www.bt.cdc.gov/workbook/pdf/ph_workbook_summary.pdf
Entire book: http://www.bt.cdc.gov/workbook/pdf/ph_workbook_draft.pdf

U. S. Department of Transportation
Emergency Preparedness Guidelines for People with Disabilities
http://www.dotcr.ost.dot.gov/asp/emergencyprep.asp

National Organization on Disability – Emergency Preparedness Resources
http://www.nod.org/Resources/emergency/dot_guidelines.pdf or word format at
http://www.nod.org/Resources/emergency/dot_guidelines.doc

Saving Lives: Including People with Disabilities in Emergency Planning
http://www.ncd.gov/newsroom/publications/2005/pdf/saving_lives.pdf

A Guide for Emergency Managers, Planners, and Responders
http://www.nod.org/resources/PDFs/epiguide2005.pdf

***American Red Cross* – Preparedness** http://www.prepare.org/
People with Disabilities: http://www.prepare.org/disabilities/disabilities.htm

FEMA
Emergency Planning and Special Needs Populations
http://www.fema.gov/pdf/library/pfd_all.pdf or http://www.fema.gov/txt/library/pfd_all.txt

***FEMA Independent Study Program*: IS-701 Multi-agency Coordination System (MACS) Course** http://training.fema.gov/emiweb/is/is701.asp

Evacuation

Disaster Management Initiative
https://www.disasterhelp.gov/suite/

Employer's Guide to Including Employees with Disabilities in Emergency Evacuation Plans
http://www.jan.wvu.edu/media/emergency.html

Emergency Evacuation Preparedness *- Taking Responsibility for Your Safety - A Guide for People with Disabilities* http://www.cdihp.org/evacuation/emergency_evacuation.pdf

U.S. Government Accountability Office *Transportation Issues for Disadvantaged Populations*
http://www.gao.gov/new.items/d0744.pdf

Notification

An ADA Guide for Local Governments:
Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities
http://www.usdoj.gov/crt/ada/emergencyprepguide.htm or
http://www.usdoj.gov/crt/ada/emerprepguidescrn.pdf

FCC – *Communicating During Emergencies*
http://www.fcc.gov/cgb/emergency/

Watchfire - http://www.watchfire.com/ - accessibility requirements for web pages

WebXACT – http://bobby.watchfire.com/bobby/html/en/index.jsp -

Shelter

Citizens Energy Corporation – Application for delivery of shelters
http://www.citizensenergy.com/APohShelters.htm

Special Needs Sheltering Assessment Tool
http://www.add-em-conf.com/abstracts/SpNS_Plan_Assessment_Tool-03-23-2006.pdf

Sample Emergency Needs Questionnaire
http://www.add-em-conf.com/abstracts/Special_Needs_Questionaire.pdf

Disaster Recovery

National Voluntary Organizations Active in Disaster http://www.nvoad.org

NVOAD Long Term Recovery Manual
http://nvoad.org/articles/LTRManualFinalApr232004a.pdf
The documents found on this page help to define the VOAD movement. Permission is given to duplicate and distribute them subject to clear identification of both the author and National Voluntary Organizations Active in Disaster (NVOAD) as well as the web address from which the information was retrieved: http://www.nvoad.org. In this way, we hope that they will be of value to others around the world serving the cause of disaster response and relief.

FEMA Long-Term Community Recovery (LTCR) Planning Process Self-Help Guide
http://www.fema.gov/pdf/rebuild/ltrc/selfhelp.pdf

Lutheran Disaster Response Database http://www.lrrnd.org/Disaster%20response.html

State of Missouri – good examples
Community Organizations Active in Disaster http://sema.dps.mo.gov/COAD.pdf

Information on Accessible Facilities

***The Center for Universal Design* – Resources**
http://www.design.ncsu.edu/cud/about_ud/udresourcepage.htm

The Seven Principles of Universal Design

1. **Equitable Use:** The design is useful and marketable to any group of users.
2. **Flexibility in Use:** The design accommodates a wide range of individual preferences and abilities.
3. **Simple and Intuitive Use:** Use of the design is easy to understand.
4. **Perceptible Information:** The design communicates necessary information effectively to the user.
5. **Tolerance for Error:** The design minimizes hazards and the adverse consequences of accidental or unintentional actions.
6. **Low Physical Effort:** The design can be used efficiently and comfortably.
7. **Size and Space for Approach and Use:** Appropriate size and space is provided for approach and use.

***ADA Standards for Accessible Design* - U.S. Dept. of Justice**
http://www.usdoj.gov/crt/ada/adastd94.pdf or http://www.usdoj.gov/crt/ada/reg3a.html#Anchor-Appendix-52467

Restoration and Accommodations

Alphabetical list of accommodations by type of disability
http://www.jan.wvu.edu/media/atoz.htm

Service and Companion Animals

Disabilities Rights Center of NH http://www.drcnh.org/serviceanimals.htm

Disaster Services Program of The Human Society of the United States (HSUS) -
http://www.hsus.org/hsus_field/hsus_disaster_center/about_hsus_disaster_services.html
The HSUS Disaster Services staff have information to help plan for the needs of pets, horses and livestock before, during and after any disaster, whether natural or human-made.

Animals in Emergency – NH Legislation HB 1435
In cases of emergency it is state policy that service animals not be separated from the persons they serve. http://www.gencourt.state.nh.us/legislation/2006/HB1435.html

Animal Shelters in NH - Listing of licensed shelters currently in NH including several Society for the Prevention of Cruelty to Animals (SPCA). http://www.agriculture.nh.gov
Click the upper right menu “hot topics” and scroll down to “animals & disasters”.

Wheelchairs, Portable Ramps, Assistive Devices

***NH Assistive Technology* 1-800-932-5837** http://www.nhassistivetechnology.org/rem/#about
Refurbished Equipment Marketplace 1-800-427-3338

General Information on Disabilities

Americans with Disabilities Act – ADA Homepage http://www.usdoj.gov/crt/ada/adahom1.htm

Disability Is Natural http://www.disabilityisnatural.com/

Children:
Parent Information Center http://www.parentinformationcenter.org

New Hampshire Partners in Health http://www.nhpih.dartmouth.edu

Council for Children & Adolescents with Chronic Health Conditions http://www.ccach.org

Seniors:
American Association of Retired Persons (AARP)
7 Ways to Disaster-Proof Your Life http://www.aarp.org/bulletin/yourlife/katrina_7_ways.html

We Can Do Better: Lessons Learned for Protecting Older Persons in Disasters
http://www.aarp.org/research/assistance/lowincome/better.html

Difficult Conversations: Evacuation of Older Persons
http:///www.aarp.org/research/academic/conversations_evacuations_of_older_persons.html

Services & Resources for People Who Are Blind/Visually Impaired

NH Sight Services for Independent Living - 603-271-3537
http://www.ed.state.nh.us/education/doe/organization/adultlearning/VR/SSIL.htm

NH Association for the Blind - 603-224-4039
http://www.sightcenter.com/

Maxi-Aids http://www.maxiaids.com/store/default.asp?idstore=1&category=Blind/Low_Vision_Store

Vision Dynamics
http://www.visiondynamics.com/default.asp?Client=8&lang=3&IDCatExp=456&DoAction=Show

Services & Resources for People with Cognitive Disabilities

Developmental Disabilities Council of NH - 603-271-3236
http://www.nhddc.org/; 1-
Planning for a Pandemic/Epidemic or Disaster: Caring for persons with cognitive impairments
http://www.ahca.org/flu/pandemic_dementia_care.pdf

Services & Resources for People Who Are Deaf/Hard-of-Hearing

NH Services for the Deaf and Hard-of-Hearing - Adult Learning and Rehabilitation Division, New Hampshire Department of Education
http://www.ed.state.nh.us/education/doe/organization/adultlearning/VR/DeafandHardofHearing.htm
Granite State Independent Living – **Deaf Services** - 603-228-9680 (V)
http://www.gsil.org/events_deafservices.php; 1-888-396-3459 (Videophone/Direct TTY)

Northeast Deaf and Hard-of-Hearing **(NDHHS)** 603-224-1850(Voice); 603-224-0691(TTY); Video Phone: 70.88.199.237; http://www.ndhhs.org/

Relay New Hampshire http://www.relaynewhampshire.com/

NH Emergency Interpreter Referral Service (after standard business hours) 1-800-552-3202

Hartling Communications 1-800-475-3183
http://www.hearitbetter.com/channels/home/2005/1116853906/index.shtm

Services & Resources for People with Mental Health Issues

NH Bureau of Behavioral Health – 603-271-5007
http://www.dhhs.state.nh.us/DHHS/BBH/default.htm

National Alliance on Mental Illness New Hampshire - NAMI New Hampshire
(603) 225-5359; (800) 242-6264 (in NH) - www.naminh.org

Substance Abuse and Mental Health Services Administration
http://mentalhealth.samhsa.gov/disasterrelief/

National Mental Health Information Center – Disaster/Trauma publications list
http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=181&Topic=Disaster%2FTrauma

NH Disability Related Organizations

NH Governor's Commission on Disability - 603-271-2773
http://www.nh.gov/disability/index.html; 1-800-852-3405 (in NH only)

Granite State Independent Living – http://www.gsil.org;
1-800-826-3700(V); 603-228-9680(V); 1-888-396-3459 (Videophone and Direct TTY)

Disabilities Rights Center of NH – 1-800-834-1721; 603-228-0432
http://www.drcnh.org/index.htm

NH Office of Minority Health – I- 800-735-2964; 603-271-3986
http://www.dhhs.state.nh.us/DHHS/MHO/default.htm

New England ADA Technical Assistance and I. T. Center
1-800-949-4232 http://www.adaptenv.org/neada/index.php